Children's MINNESOTA | Partners in Pediatrics

BROOKLYN PARK OFFICE
8500 Edinbrook Parkway
Brooklyn Park MN 55443
(763) 425-1211
FAX (612) 874-2907

CALHOUN OFFICE
3910 Excelsior Boulevard
St Louis Park MN 55416
(952) 562-8787
FAX (612) 874-2909

MAPLE GROVE OFFICE
Maple Grove Mall
12720 Bass Lake Road
Maple Grove MN 55369
(763) 559-2861
FAX (612) 874-2902

PLYMOUTH OFFICE
WestHealth
2855 Campus Drive, #350
Plymouth MN 55441
(763)520-1200
FAX (612) 874-2908

ROGERS OFFICE
13980 Northdale Boulevard
Rogers MN 55374
(763) 428-1920
FAX (612) 874-2916

www.pipstop.com

ADHD TRANSFER OF CARE

Thank you for transferring care to Partners in Pediatrics for your child's attention and/or school difficulties. In order to provide the quality of care you expect from us, we require a 40 minute first visit to acquaint ourselves with your child's medical history and perform a physical examination.

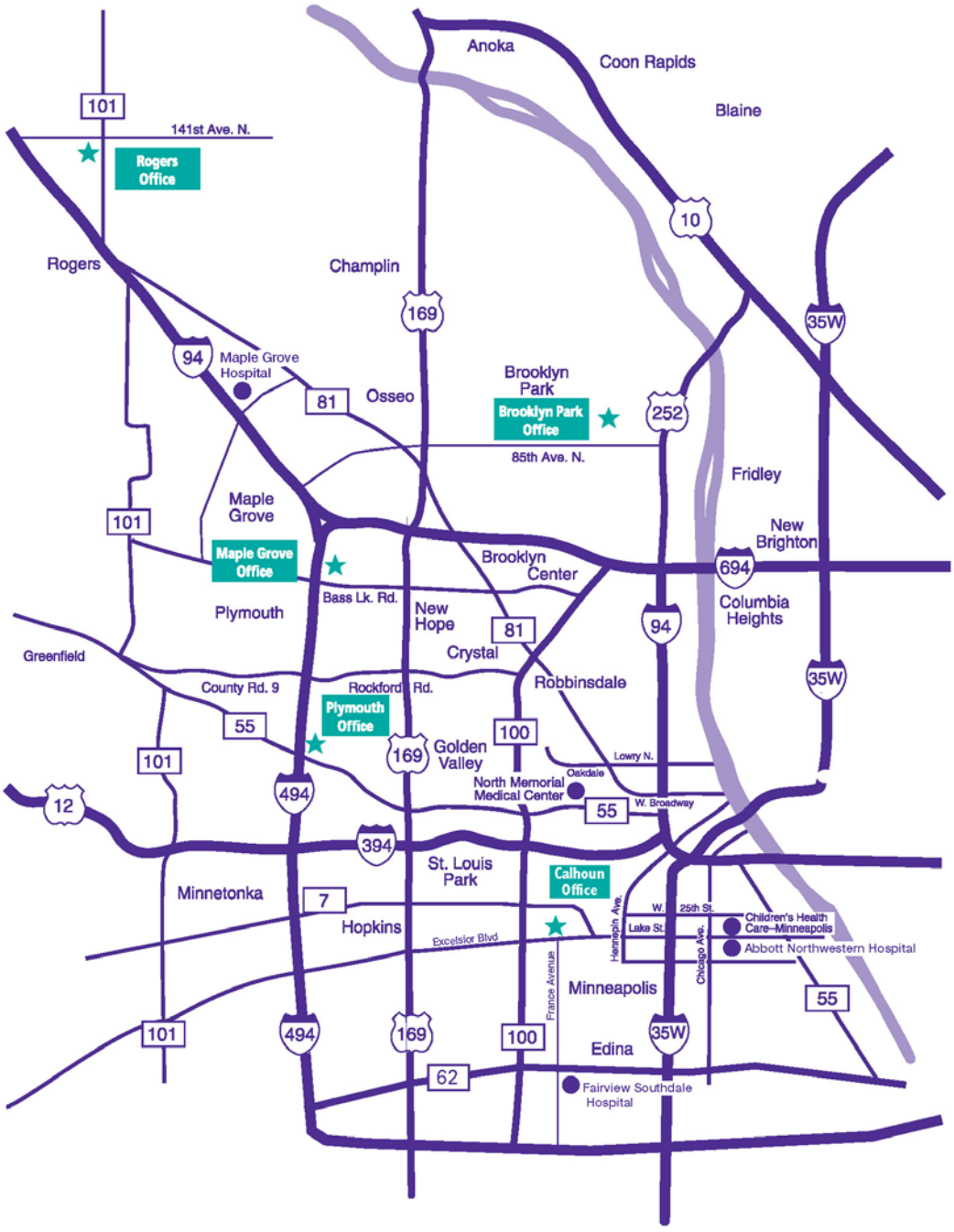
To help us become familiar with your child's current situation, please have the enclosed separate parent and teacher questionnaires completed. Please fill out the entire parent packet and give the teacher packet to one or more of your child's teachers. Choose those teachers who know your child best. If your child is in Middle School or High School, each teacher will need to complete a packet. Ask the teachers to complete the forms as soon as possible. Please also obtain copies of any previous medical records, consultations and school or private psychological evaluations and a recent report card. **It is extremely important to have all of the completed forms and copies of previous evaluations available at the time of the appointment.** It is often better that you bring these with you rather than rely on school staff or other offices to send the information in on time.

These services are most often covered under your health plan. However, please contact your insurance company directly about this coverage prior to the time the evaluation begins. You may contact our business office to discuss payment arrangements.

Your appointment is scheduled with _____ as follows:

DATE	***TIME***	***LOCATION***	***WHO SHOULD ATTEND***
		❑ Brooklyn Park ❑ Calhoun ❑ Maple Grove ❑ Plymouth ❑ Rogers	Parent(s) and Child

Please contact your child's office (see back) if you have any problems, questions, or need to reschedule your appointment.



BROOKLYN PARK OFFICE Phone 763-425-121 8500 Edinbrook Parkway Brooklyn Park, MN 55443	CALHOUN OFFICE Phone 952-562-8787 3910 Excelsior Boulevard St Louis Park MN 55416	MAPLE GROVE OFFICE Phone 763-559-2861 Bass Lake Center 12720 Bass Lake Road Maple Grove, MN 55369
PLYMOUTH OFFICE Phone 763-520-1200 West Health Campus 2855 Campus Drive, #350 Plymouth, MN 55441	ROGERS OFFICE Phone 763-428-1920 13980 Northdale Boulevard Rogers MN 55374	

Children's MINNESOTA
Partners in Pediatrics

SCHOOL PROBLEMS EVALUATION
MEDICAL HISTORY FORM

Child's name: _____

Birthdate: _____ Date form filled out: _____

Your name: _____ Primary Phone: _____

Relationship to child: _____ Secondary Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Name of School: _____ Grade: _____

Referred by: _____

Child's private physician: _____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

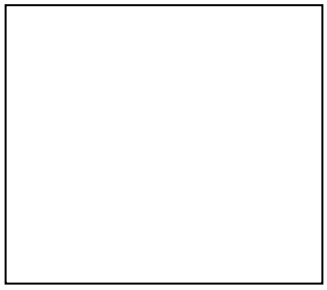
Date Name of Physician, psychologist, agency, or clinic

_____

_____

_____

Please attach a recent picture:



Name: _____ Date of Birth: _____

Please list the problems with which you want help for your child:

1. _____
2. _____
3. _____
4. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

_____

_____

SCHOOL

Please describe your child's current classroom placement and services (attach an Individual Educational Plan [IEP] and copies of any school psycho-educational reports if available):

Special Services Time/days per week

_____

_____

_____

Please indicate current classroom interventions:

- ❒ Behavior chart
- ❒ Seating preference
- ❒ Time to think or behavior room
- ❒ Social skills group
- ❒ Other _____

School performance: What has the school told you about your child's:

Behavior? _____

_____

Work completion? _____

_____

Academic progress? _____

_____

Does your child often bring home work that should have been done during class time? ❒ Yes ❒ No

Handwriting/ neatness: _____

_____

Please describe previous day care, preschool or school problems:

Grade/year School/Center name Problems

_____

_____

_____

_____

_____

Name: _____ Date of Birth: _____

HOME/FAMILY

Family Member	Name	Years of School/Degree	Occupation
Father			
Mother			
Stepfather			
Stepmother			

Parents are: ❒ married ❒ separated ❒ divorced ❒ never married

Please share any history of significant (if any) marital problems: _____

Custody arrangements if applicable: _____

Who lives at home with this child? _____

Briefly describe any behavior or family issues that bother you in regard to this child:

Please describe any conflict surrounding homework: _____

Please describe how you discipline your child: _____

SOCIAL

How many close friends does your child have? _____

Describe any problems your child may have in making and keeping friends: _____

Please describe any aspect of your child's social life that bothers you: _____

List the organized or leisure time activities your child participates in (e.g.., sports, scouts, religious, free time play):

How many hours per day does your child watch TV and play video games? _____

Name: _____ Date of Birth: _____

SELF-ESTEEM

How do you feel these problems are affecting your child's self-esteem? _____

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

Was this child adopted? ❒ Yes ❒ No

PREGNANCY

Was this pregnancy planned? ❒ Yes ❒ No

PREGNANCY COMPLICATIONS	Yes	No
Bleeding		
Premature labor		
High blood pressure		
Toxemia		
Infections		
Weight gain less than 15 lbs.		
Diabetes		
Smoking		
Drug use *		
Alcohol use: # of drinks/day _____		
Emotional or family problems *		
Previous stillborns/miscarriages		

Specify any medications/drugs or other details:

_____

_____

_____

_____

_____

_____

_____

LABOR AND DELIVERY:

Length of pregnancy: _____ Type of delivery: ❒ Vaginal ❒ Cesarean

Mother's age at delivery: _____

Complications:

❒ fetal distress (heart rate drop)
❒ meconium (bowel movement) passage before birth
❒ forceps use
❒ breech delivery
❒ other, describe _____

NEWBORN HISTORY:

Birth weight: _____ lbs. _____ oz.

Complications at birth (check those that apply):

❒ None
❒ Needed oxygen
❒ Difficulty breathing/respiratory distress
❒ Treated in an intensive care unit (NICU)
❒ Jaundice
❒ Low blood sugar
❒ Infection/ pneumonia
❒ Other: _____

Name: _____ Date of Birth: _____

GROWTH

Has your child had any problems with (if yes, please describe):

Weight loss or gain: ❒ No ❒ Yes: _____

Growth in height or length: ❒ No ❒ Yes: _____

Head size: ❒ No ❒ Yes: _____

Additional details or comments: _____

_____

_____

DEVELOPMENT

Did your child's development seem normal compared to other children? ❒ No ❒ Yes

Developmental milestone	**Age Achieved**
Rolled over	
Sat alone	
Walked alone	
First words (mama-dada)	
Two word sentences	
Toilet trained – days	
Toilet trained – nights	
Dress self	

BEHAVIOR HISTORY:

If your child has experienced any of these behavior problems, please record the ages they occurred.

BEHAVIOR	**NO**	**YES**	**AGES**
Colic			
Infant feeding problems			
Difficulty falling asleep			
Difficulty staying asleep			
Excessive crying			
Tantrums			
Difficulty being consoled			
Overactivity or hyperactivity			
Difficulty keeping to a schedule			
Difficulty being satisfied or easily bored			
Thumb sucking			
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Name: _____ Date of Birth: _____

FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family other than your child may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

FAMILY HISTORY	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Others (Specify)
LEARNING					
Difficulty with reading					
Difficulty with arithmetic/math					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Mental retardation					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression/bipolar					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
Smoking or chewing tobacco					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

Father's age: _____

Mother's age: _____

Sister(s) name and ages: _____

Brother(s) name and ages: _____

Name: _____ Date of Birth: _____

FAMILY HEART HISTORY:

If a member of your child's family has had any of these medical problems, please record their relationship to your child.

PROBLEM	NO	YES	RELATIONSHIP
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

CHILD'S HEART HISTORY:

If your child has experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

CHILD'S MEDICAL HISTORY:

Are immunizations up to date? ❒ No ❒ Yes (Please include a copy of current immunization records)

Describe any serious reactions: _____

List any known allergies to medications, foods, pollens or inhalants: _____

_____

_____

Describe any hospitalizations or surgery (date, reason, problems): _____

_____

_____

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): _____

_____

_____

Name: _____ Date of Birth: _____

MEDICATIONS:

Please list currently prescribed or over the counter medications taken and their doses:

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS:

If your child has experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods Problems			
Age menstruation started _____			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other (specify)			

Children's MINNESOTA
Partners in Pediatrics

PARENT SCHOOL PROGRESS FOLLOW-UP EVALUATION

Parent to Complete in the month of _____

Child's Name: _____ Date of Birth: _____ Today's Date: _____

Parent's Name: _____ Parent's Phone Number: _____

- Are your child's ADHD symptoms controlled consistently throughout the day? ❑ Yes ❑ No
- If your child is currently taking ADHD medication, how long does it control his/her symptoms? _____ Hours.
- Are your child's ADHD symptoms controlled during after-school hours including homework time? ❑ Yes ❑ No
- If not, what ADHD symptoms are not adequately controlled during this time? _____

_____

- Do you feel that your child needs more symptom control than what is provided by his/her current ADHD treatment plan? ❑ No ❑ Yes
- Do you feel that your child's current or prior ADHD medication is/was well tolerated? ❑ Yes ❑ No

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat when remaining seated is expected.	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected.	0	1	2	3
13. Has difficulty playing or beginning quiet play activities.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor".	0	1	2	3
15. Talks too much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues with adults.	0	1	2	3
20. Loses temper.	0	1	2	3
21. Actively defies or refuses to go along with adults' requests and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	0	1	2	3
24. Is touchy or easily annoyed by others.	0	1	2	3
25. Is angry or resentful.	0	1	2	3
26. Is spiteful and wants to get even.	0	1	2	3
27. Is fearful, anxious, or worried.	0	1	2	3
28. Is afraid to try new things for fear of making mistakes.	0	1	2	3
29. Feels worthless or inferior.	0	1	2	3
30. Blames self for problems, feels guilty.	0	1	2	3
31. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
32. Is sad, unhappy, or depressed.	0	1	2	3
33. Is self-conscious or easily embarrassed.	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
34. Overall school performance	1	2	3	4	5
35. Reading	1	2	3	4	5
36. Writing	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Relationships with parents.	1	2	3	4	5
39. Relationships with siblings.	1	2	3	4	5
40. Relationships with peers.	1	2	3	4	5
41. Participation in organized activities (e.g. teams)	1	2	3	4	5

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	NONE	MILD	MODERATE	SEVERE
Change of appetite	0	1	2	3
Weight loss	0	1	2	3
Trouble sleeping	0	1	2	3
Dull, tired, listless behavior	0	1	2	3
Chest pain	0	1	2	3
Stomachache	0	1	2	3
Headache	0	1	2	3
Tremors/feeling shaky	0	1	2	3
Repetitive movements, tics, jerking, twitching, eye blinking	0	1	2	3
Picking at skin or fingers, nail biting, lip or cheek chewing	0	1	2	3
Irritability in the late morning, late afternoon, or evening	0	1	2	3
Problem behaviors when medications are wearing off	0	1	2	3
Excessive worrying, anxiety	0	1	2	3
Sees or hears things that aren't there	0	1	2	3
Socially withdrawn – decreased interaction with others	0	1	2	3
Extreme sadness or unusual crying	0	1	2	3
Dizziness	0	1	2	3
Skin rash	0	1	2	3

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS**

❑ Brooklyn Park office	❑ Calhoun office	❑ Maple Grove office	❑ Plymouth office	❑ Rogers office
8500 Edinbrook Parkway Brooklyn Park MN 55443 Phone: 763-425-1211 Fax: 612-874-2907	3910 Excelsior Boulevard St Louis Park MN 55416 Phone: 952-562-8787 Fax: 612-874-2909	12720 Bass Lake Road Maple Grove MN 55369 Phone: 763-559-2861 Fax: 612-874-2902	2855 Campus Drive, #350 Plymouth MN 55441 Phone: 763-520-1200 Fax: 612-874-2908	13980 Northdale Boulevard Rogers MN 55374 Phone: 763-428-1920 Fax: 612-874-2916

For Office Use Only

Inattention 1-9: _____/9 Hyp-Imp 10-18: _____/9 ODD 19-26: _____/8 Dep / Anx 27-33 _____/7

Strengths: Weaknesses:

Provider Initials:_____

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Children's MINNESOTA | Partners in Pediatrics

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

INSTRUCTIONS	✓ Make sure all blanks are filled in; failure to do so may prevent or delay release of information. ✓ Read the statement about obtaining copies of medical records printed at the bottom of this form.
PATIENT IDENTIFICATION (print)	Patient's Name(s): _____ Birthdate(s): _____ Address: _____ _____ Parents/Guardian: _____
Who is releasing the information?	❑ Partners in Pediatrics, an affiliate of Children's Hospitals and Clinics of Minnesota (Children's) ❑ Other healthcare provider/clinic/hospital. Please provide the name and address: _____ _____ _____
Where do you want the information sent?	Name and Address: _____ _____ _____
INFORMATION REQUESTED	❑ Office notes for the past two years (includes all items below) ❑ Immunization records ❑ Psychological reports/testing ❑ Hospital/surgical summaries ❑ Education testing results/reports ❑ X-ray/lab reports ❑ Other/specify dates of service: _____
PURPOSE OF RELEASE	❑ Insurance change/transfer ❑ Referral/consultation ❑ Mutual exchange of information ❑ Other: _____
TIME LIMIT	I understand I can revoke this authorization at any time in writing. Revocation will not apply to information already disclosed with this authorization. This authorization is valid for disclosure and/or information disclosed for purposes of treatment, payment, and health care operations and for other purposes for one year until revoked.
REVIEW OF RECORDS	You may, in the presence of PIP staff, inspect or copy the information for use or disclosure with this Authorization for Disclosure.
ACKNOWLEDGMENT OF UNDERSTANDING	• I understand that once information is released pursuant to this authorization, Partners in Pediatrics (affiliate of Children's) cannot prevent the re-disclosure of the information to another third party • Partners in Pediatrics (affiliate of Children's) will not condition treatment or payment of claims on my signing this authorization. • I understand this authorization must be filled out completely, signed and dated in order to be considered valid. • I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. • I understand that the original, a photocopy, or a facsimile of this completed form will be considered valid.
TODAY'S DATE AND SIGNATURE (Parent or guardian, or patient if over 18)	Signature: _____ Date: _____ Relationship to patient: _____ Daytime phone: _____

RECORDS FROM OTHER FACILITIES: It is the policy of Partners in Pediatrics (affiliate of Children's) to release only medical information documented/dictated by Partners in Pediatrics (affiliate of Children's) health care providers. If you have been treated by other health care providers, please contact them and make arrangements to release any information you may need.

Initials of PIP/copy service staff releasing information: _____ # of pages: _____ Date: _____

Authorization request faxed/mailed to: _____ Staff initials: _____ Date: _____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

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PATIENT IDENTIFICATION (print)	Patient's Name(s): _____ Birthdate(s): _____ Address: _____ _____ Parents/Guardian: _____
Who is releasing the information?	❑ Partners in Pediatrics, an affiliate of Children's Hospitals and Clinics of Minnesota (Children's) ❑ Other healthcare provider/clinic/hospital. Please provide the name and address: _____ _____ _____
Where do you want the information sent?	Name and Address: _____ _____ _____
INFORMATION REQUESTED	❑ Office notes for the past two years (includes all items below) ❑ Immunization records ❑ Psychological reports/testing ❑ Hospital/surgical summaries ❑ Education testing results/reports ❑ X-ray/lab reports ❑ Other/specify dates of service: _____
PURPOSE OF RELEASE	❑ Insurance change/transfer ❑ Referral/consultation ❑ Mutual exchange of information ❑ Other: _____
TIME LIMIT	I understand I can revoke this authorization at any time in writing. Revocation will not apply to information already disclosed with this authorization. This authorization is valid for disclosure and/or information disclosed for purposes of treatment, payment, and health care operations and for other purposes for one year until revoked.
REVIEW OF RECORDS	You may, in the presence of PIP staff, inspect or copy the information for use or disclosure with this Authorization for Disclosure.
ACKNOWLEDGMENT OF UNDERSTANDING	• I understand that once information is released pursuant to this authorization, Partners in Pediatrics (affiliate of Children's) cannot prevent the re-disclosure of the information to another third party • Partners in Pediatrics (affiliate of Children's) will not condition treatment or payment of claims on my signing this authorization. • I understand this authorization must be filled out completely, signed and dated in order to be considered valid. • I understand that in compliance with MN Statute 144.33 and WI Administrative Code HHS117, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records. • I understand that the original, a photocopy, or a facsimile of this completed form will be considered valid.
TODAY'S DATE AND SIGNATURE (Parent or guardian, or patient if over 18)	Signature: _____ Date: _____ Relationship to patient: _____ Daytime phone: _____

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Initials of PIP/copy service staff releasing information: _____ # of pages: _____ Date: _____

Authorization request faxed/mailed to: _____ Staff initials: _____ Date: _____

Children's MINNESOTA
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TEACHER SCHOOL PROGRESS FOLLOW-UP EVALUATION

Teacher to Complete in the month of _____

Child's Name: _____ Grade Level: _____ Today's Date: _____

Teacher's Name: _____ Class Name/subject: _____ Class Time /Period: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat when remaining seated is expected.	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected.	0	1	2	3
13. Has difficulty playing or beginning quiet play activities.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor".	0	1	2	3
15. Talks too much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues with adults.	0	1	2	3
20. Loses temper.	0	1	2	3
21. Actively defies or refuses to go along with adults' requests and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	0	1	2	3
24. Is touchy or easily annoyed by others.	0	1	2	3
25. Is angry or resentful.	0	1	2	3
26. Is spiteful and wants to get even.	0	1	2	3
27. Is fearful, anxious, or worried.	0	1	2	3
28. Is afraid to try new things for fear of making mistakes.	0	1	2	3
29. Feels worthless or inferior.	0	1	2	3
30. Blames self for problems, feels guilty.	0	1	2	3
31. Feels lonely, unwanted, or unloved; complains that "no one loves him or her".	0	1	2	3
32. Is sad, unhappy, or depressed.	0	1	2	3
33. Is self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
34. Following directions	1	2	3	4	5
35. Disrupting class	1	2	3	4	5
36. Assignment completion	1	2	3	4	5
37. Organizational skills	1	2	3	4	5
38. Relationships with peers	1	2	3	4	5
48. Reading – accuracy of work completed	1	2	3	4	5
49. Mathematics – accuracy of work completed	1	2	3	4	5
50. Written expression - accuracy of work completed	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Child's Name: _____ Date of Birth: _____

COMMENTS:

Please return this form to: **PARTNERS IN PEDIATRICS** or send to parents

❑ Brooklyn Park office 8500 Edinbrook Parkway Brooklyn Park MN 55443 Phone: 763-425-1211 Fax: 612-874-2907	❑ Calhoun office 3910 Excelsior Boulevard St Louis Park MN 55416 Phone: 952-562-8787 Fax: 612-874-2909	❑ Maple Grove office 12720 Bass Lake Road Maple Grove MN 55369 Phone: 763-559-2861 Fax: 612-874-2902
❑ Plymouth office 2855 Campus Drive, #350 Plymouth MN 55441 Phone: 763-520-1200 Fax: 612-874-2908	❑ Rogers office 13980 Northdale Boulevard Rogers MN 55374 Phone: 763-428-1920 Fax: 612-874-2916	

For Office Use Only

Inattention 1-9: _____/9 Hyp-Imp 10-18: _____/9 ODD 19-26: _____/8 Dep / Anx 27-33: _____/7

Academic Strengths: Academic Weakness:

Provider Initials:_____

F15-050